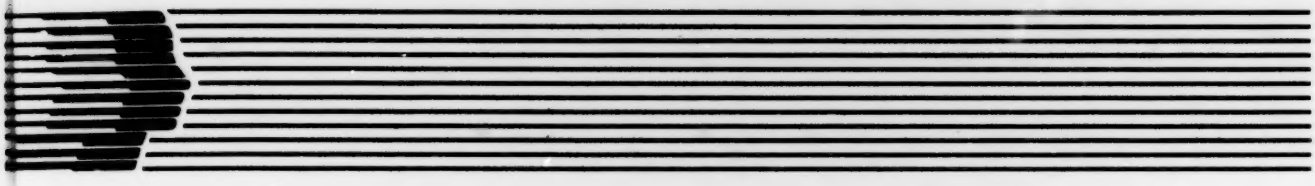
Women's
Policy Office



Government of
Newfoundland and Labrador

WOMEN'S HEALTH ISSUES

By Wendy Williams

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FOREWORD

In 1988 the Women's Policy Office contracted with Wendy Williams, a well-known figure in both the women's and health care communities in Newfoundland and Labrador, to examine women's health issues in the province. We felt such research was important because conventional health care studies often minimize both women's role in providing health care and health care issues unique to women. The following report details the results of Wendy's research.

The report was written by Wendy Williams, then edited and prepared for publication by Judy Snow, Public Relations Specialist with the Women's Policy Office.

ACKNOWLEDGMENTS

The people who allowed me to interview them for this study were very generous with both their time and their knowledge. I am most appreciative of their help, for without it this work could not have been done.

Many women have spent long hours both telling and teaching me about life in general and their lives in particular. What they told me was very different from what I had learned in my nursing education. Their sharing of their experiences started my questioning of my education and the health care system. Thank you to all these women.

This is the first opportunity I have had to integrate my feminist and my nursing goals and to put them on paper. I am not sure I have succeeded, but it has been a stimulating experience to attempt to do so.

When working to change the world, as all feminists are, it helps to have a vision of what is wanted. The following is one vision of a healthy world, which was produced cooperatively at workshops organized by the City of Toronto's Health Department. I am working towards this vision, and I hope this study will prove to be one of the pieces needed to bring it about.

VISION STATEMENT

(1) a long life in good health - both as a resource for everyday living and as a reflection of our society

(2) health for all - the basic prerequisites for health must be available to everyone equally

(3) a clean, green, quiet and healthy environment - a sustainable ecosystem

(4) placing people above material things - a society that is human-centred and built on human scale

(5) a caring, sharing, cooperative and supportive community

(6) active participation by individuals and communities to increase control over and improve their health

(7) a meaningful role for each individual in society to enhance self-esteem and self-worth

(8) a world where reproductive labour is as valued as productive labour (Please note that this eighth part is my addition.)

EXECUTIVE SUMMARY

Women's health is important for two reasons: because the health of individual women is important and because women are the main providers of health care in our province. This demanding work is unrecognized by the formal health care system. In fact, the professional world denies this work by their very use of the term "primary health care" to describe the work done by family doctors and public health nurses. Policy makers have to recognize the work women do as hidden health care providers and develop policies which recognize and value this role. Health care policies which work against women must be eliminated.

Women define health in the broadest of terms. When asked to give major health concerns for women, they speak about issues ranging from the need for women to improve their self image, women's lack of adequate finances, of child care facilities, of support systems, to the lack of native health professionals.

Canadians in general and Newfoundlanders in particular have received many benefits from our present health care system, which is based on a curative model of care. But fine tuning of this system will no longer produce improvements in our health. The health care system must be changed from a curative to a preventive model. Women must be involved at every stage as this change in focus becomes a reality.

Economic factors have been acknowledged as a major determinant of health. Newfoundland women are poor. Attempts to improve our health will have to be based on the goal of providing women with an adequate standard of living. Any system designed to do this will have to acknowledge women's work, both in the home and in the world of paid work.

The issues and solutions raised by women cross the boundaries of government departments. Changes at the governmental level must come through cooperation across these boundaries.

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WHY WOMEN'S HEALTH NEEDS MUST BE ADDRESSED

The United Nations declared 1976 - 1985 the "Decade for Women." Activities that took place during the decade focused both national and international attention on women's disadvantaged status and on strategies for achieving social, economic, and political equality between the sexes. The World Conference to Review and Appraise the Achievements of the United Nations' Decade for Women: Equality, Development and Peace, held in Nairobi in July of 1985, marked the end of the decade. One outcome of the World Conference was the adoption of *The Nairobi Forward-Looking Strategies for the Advancement of Women.*

The Forward-Looking Strategies (FLS) are a set of goals and activities intended to help advance women's status as the year 2000 approaches. The FLS recognize the important role of improvements in women's physical and mental health as part of the concrete basis for progress towards equality. (See appendix C for its recommendations relating to women's health.)

The decision by Canada's Ministers Responsible for the Status of Women to address women's health at their June 1988 meeting was part of a world-wide recognition that improving women's health is a necessary part of the equality process.

Any analysis of women's health in Newfoundland and Labrador has to be placed in the context of what is happening in two areas: the health field and the women's community. This study reviews that this happening in these areas, in our province, in Canada, and around the world.

BACKGROUND

The Health Care System

Canada as a federation of provinces has a division of powers between the two levels of government, provincial and federal. Health is a shared jurisdiction, with the provincial governments having responsibility for the delivery of health care to their citizens, and the federal government partially responsible for funding the system.

A brief history of our existing health care system will explain how it developed.

Up until World War II the public health approach held the most influence on health policy. This was based on Edwin Chadwick's report in 1842, which recommended good sanitation, the provision of clean water, and the removal of garbage. Canada's system began to shift focus in the 1950s by moving away from this public health approach toward a curative model of health care.

Curative medicine is aimed primarily at curing individuals. It is represented by the services delivered by doctors in hospitals. Treatment by drugs also became associated with this type of care because it was the doctor who, by and large, acquired the right to administer drugs. Until recently, the curative care model has provided the common intellectual structure for policy analysis in health. This model has determined the parameters of the problems perceived by policy makers and their solutions. The problems within this model or paradigm are always perceived as occurring within the confines of a curative, highly technological, and scientific approach to the health of individuals.

In 1958 the *Hospital Insurance and Diagnostic Services Act* was enacted to cover the cost of hospital services. Another piece of federal legislation, the *Medical Care Act*, was passed in 1966 to encompass the cost of physician services as well. Given that the *British North America Act* assigned the primary responsibility for health matters to the provinces, the federal government, through this legislation, exercised its constitutional spending powers by offering the provinces contributions towards the cost of insured hospital and physician services. Criteria were established which provinces had to meet in order to qualify for the federal money. These criteria provided that all essential medical and hospital services

would be available to every resident of a province on uniform terms and conditions. By 1971 all provinces subscribed to both programmes.

In 1984, the *Hospital Insurance and Diagnostic Services Act* and the *Medical Care Act* were repealed and replaced by the *Canada Health Act*. There are five principles or standards of health care contained in the *Canada Health Act*: comprehensiveness, accessibility, universality, portability, and public administration. While this Act allows the definition of health care provider to be expanded beyond the physician, the underlying model is still curative.

Change in the Canadian Health Community

While expenditures are increasing in the Canadian health care system, the increased money is not resulting in improved health for our citizens. Politicians and health professionals are thus re-examining the curative model of care which forms the basis of our health care system, and investigating the preventive model of care as a way to both control costs and increase the level of health. In fact, the evidence is clear. Major improvements in public health have been due primarily to such projects as ensuring clean water, proper waste disposal, availability of wholesome food, better housing, and family planning.

Vaccines, antibiotics, and other recent medical interventions have also played a small but significant part in improving public health (City of Toronto, p. 5). Increasingly, it is accepted that health promotion and disease prevention are more effective than striving for cures, that a multi-sectorial approach is necessary, that social interventions for the common health are appropriate and may take precedence over individual concerns, and that community development is the proper approach to many health problems.

These changes started in 1974 when Marc Lalonde, Minister of Health and Welfare, published *A New Perspective on the Health of Canadians* (the Lalonde Report). It signalled the re-emergence of the public health or preventive approach to health care. The Lalonde Report showed that the health care system is only one determinant of the health of Canadians and that future improvements would result from changing environments and life styles. Preventive medicine works with groups of people or entire populations. It is aimed primarily at preventing illness and maintaining health. The preventive model is a less highly technological approach to the health of whole populations than the curative model. One of the basic principles of this approach is the continuous collaboration between consumers and providers in identifying problems, their causes and solutions. Decision-making moves from a hierarchical structure in the curative model to a more

decentralized system in the preventive model. Services would be community-based as opposed to being institutionally-based under the curative model.

The concept of a preventive model of health care as given in *A New Perspective on the Health of Canadians* was internationally hailed as the beginning of a world-wide revolution in thinking about health. While this report became world-famous, it did not result in immediate changes in Canada. But its impact is now being felt by a circuitous route, the World Health Organization.

The World Health Organization is the mechanism through which countries work together to discuss health problems and solutions. After analyzing diseases and trends in health, in 1975 the World Health Organization warned that unless radical steps were taken by the public, the professions, industry, and government, a health crisis would result by the year 2000 (Glass, p. 5). These concerns were discussed at the International Conference on Primary Health Care held at Alma Alta in the USSR in 1978. One hundred thirty-four countries, including Canada, and sixty-seven United Nations organizations attended and supported the conference findings.

The Alma Alta conference is an international landmark in the field of public health. The following guiding statement, one of several to come out of the conference, calls for a more equitable distribution of health resources:

> *In view of the magnitude of health problems and the inadequate and inequitable distribution of health resources between and within countries, and believing that health is a fundamental human right and a worldwide social goal, the Conference called for a new approach to health and health care, to close the gap between the "haves" and the "have-nots," to achieve a more equitable distribution of health resources, and to attain a level of health for all the citizens of the world that will permit them to lead a socially and economically productive life* (World Health Organization, p. 6).

Conference participants saw primary health care as one of the mechanisms which could help to improve the health status of the world's people. At Alma Alta, primary health care was defined as

> *essential care based on practical, scientifically sound and socially acceptable methods of technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part of the country's health system, of which it is the*

central and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family, and the community with the national health system, bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process (World Health Organization, p. 6).

The conference called on all governments to develop national policies, strategies, and plans of action to launch and sustain primary health care as part of a comprehensive national health system, in coordination with other sectors. While each country will set different targets and develop different strategies to meet them, WHO has prepared indicators to be used at national and international level for monitoring and evaluating progress toward the goal of "Health for All by the Year 2000." Categories of indicators to be used are:

1. Health Policy Indicators

- political commitment to health for all
- resource allocation
- the degree of equity and distribution of health services
- community involvement in attaining health for all
- organizational framework and managerial process

2. Social and Economic Indicators for Health

- rate of population increase
- gross national product or gross domestic product
- income distribution
- work conditions
- adult literacy rate
- housing
- food availability

3. Indicators of the Provision of Health Care

- coverage by primary health care
- coverage by the referral system

4. Indicators of Health Status

- nutritional status and psychosocial development of children
- infant mortality rate
- child mortality rate (1 - 4 years inclusive)
- life expectancy at birth or at other specific ages
- maternal mortality rate

The provision of primary health care as defined above is now the goal of many countries around the world. Canada is one of those countries, and we have formally stated our commitment to this goal.

Health and Welfare Canada co-hosted an international conference with WHO and the Canadian Public Health Association in Ottawa in November of 1986. At this conference 38 countries representing most of the world's industrialized nations approved the Ottawa Charter for Health Promotion. This Charter identified prerequisites for health as well as strategies for health. The prerequisites for health given in the Ottawa Charter are peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice, and equity. The five strategies to reach the goal of health for all by the year 2000 are:

(1) To Build Health Public Policy: This puts health on the agenda of policy makers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health.

(2) To Create Supportive Environments: Health cannot be separated from other goals of a complex society. The inextricable link between people and their environment constitutes the basis for a socio-ecological approach to health.

(3) To Strengthen Communities: Communities must own and control their own endeavours and destinies.

(4) To Develop Personal Skills: By providing information, education for health, and enhancing life skills, we increase the options available to people to exercise more control over their own health and over their environments, and to make choices conductive to health.

(5) To Reorient Health Services: The role of the health sector must move increasingly in a health promotion direction, beyond its responsibility for providing clinical and curative services.

Jake Epp, Minister of National Health and Welfare, released *Achieving Health for All: A Framework for Health Promotion* at this 1986 conference. This document is the federal government's plan to reach health for all by the year 2000. The federal government's strategy for achieving health for all is very similar to the Ottawa Charter, but it stresses the need to reduce inequities both in health status and in access to the basic prerequisites for health.

At the provincial level, our Department of Health has not produced a formal proposal for reaching health for all by the year 2000. In the fall of 1987, the Public Health Branch of the Department of Health released *Newfoundland Health Review*, which says that while the present health care system has improved our health, there is no evidence that further benefits can be gained from this system's direction. A change in direction to a preventive approach is necessary to see improvements in the health of our citizens. The Public Health Branch of the Department of Health receives approximately 5 percent of the total health budget, and the Review may not reflect the thinking of the entire Department of Health.

The analysis in the *Newfoundland Health Review*, which is based on the Lalonde Report, provides base-line data using the health determinants as defined by Lalonde: biological, environmental (social, physical, economic) and lifestyle factors, plus factors relating to health care organization.

One of the limitations of this work is that the goals and the strategies to reach these goals were designed by health professionals only.

Change is happening in the health sector. Women must be a part of that change. Let us turn our attention to women and their work in the area of health.

Health care researchers such as Hilary Graham have named two systems of health care, the formal and the informal. The formal system is the one we commonly call the health care system: nurses, physicians, hospitals, and our medical care plan. The informal care system is the one which is based on the work women do in their homes. Women have three different roles in this informal system. Firstly, women are the providers of health, maintaining the home as a clean, safe environment to plan and cook the food. Secondly, women are the teachers of health by role modelling. Lastly, in times of crisis, women mediate the contact with the formal health care system.

Graham says the two distinct features of the informal care system are the sexual division of labour (women do it) and the location where this work is done (within the community and the family).

Women know they perform these very important roles in health care. Women living in this province as well as elsewhere in Canada have identified that it is mainly women who provide the caring and health care in this country. But the formal health care field has never acknowledged this. In fact, health professionals are claiming to be the primary health care workers. Thus language denies women's work.

The women who gathered in Nairobi, Kenya in July of 1985 to review the U.N. Decade for Women were aware of the roles women play as health providers and health brokers. The first strategy adopted under health, paragraph 148, speaks to this very issue (see appendix C). The first step in the strategy is recognizing these double roles. The next step is developing health policies which work to decrease, not increase, the heavy load women carry.

Across Canada there are signs that the health care system and the women's community are beginning to work together to change the world. In March of 1988 a meeting was held in Ottawa entitled "Women and Tobacco." This meeting was the first national meeting where activists in the women's health movement and the organized health community met to discuss a women's health problem - smoking.

Another sign that the health community is listening to women was the report entitled *Women and Mental Health in Canada: Strategies for Change*, produced under the auspices of the Canadian Mental Association. This report examined mental health problems of women from a feminist perspective. A feminist analysis of a problem requires a feminist solution. To quote: "The general lack of recognition given to women's work in the home, coupled with the continued reluctance of men to accept that responsibility for housework and care of children should be shared equally between men and women, represents a serious obstacle to women's well-being." (Canadian Mental Health Association, p. 87)

Health and Welfare Canada sponsored a symposium "Changing Patterns of Health and Disease in Canadian Women" in April of 1988. This symposium was an initiative of Health and Welfare Canada's Plan of Action 1985-1990, based on the Nairobi Forward-Looking Strategies for the Advancement of Women to the Year 2000 and the Regional Forward-Looking Strategies on Women's Health and Development of the Pan-America Health Organization. Both the formal health care system and the women's community were there.

The final note of encouragement is the decision of Ministers' Responsible for the Status of Women to address women's health at their meeting in June of 1988.

The Women's Community

Women have been concerned about their own health and the health of their families and their communities for as long as women have been in Newfoundland and Labrador. Over the years, women have worked on many issues; and their analysis of the causes of the health problems has gradually changed. An early example of women's seeing a problem in the medical system and changing it is NONIA, the Newfoundland Outport Nursing and

Industrial Association. NONIA was started by two women, Evelyn Cave Hiscock and Lady Harris, in May of 1920. Evelyn Cave Hiscock had noticed a lack of medical services on two trips down north and one to the southwest coast. Together with Lady Harris, she decided to do something about this; and by 1921 five nurse-midwives were working in the country. In 1922 another woman, Elsie Allardyce, thought of a way in which NONIA could become self-supporting or close to it. In 1923 women in six "industrial centres" began making knitted and woven goods. Income from the sale of these goods paid the nurses' salaries, the cost of the raw materials, and the craftswomen.

The suffragists believed that equality for women lay in getting the vote for women. Unfortunately, the 1925 enfranchisement of women did not result in equality.

When the women's movement emerged in the 1970s, women tackled problems on an issue-by-issue basis. They did not see that there were any underlying connections between these problems. Health issues were at the forefront of the agenda. They put a large part of their energies in two main areas: reproductive health and violence against women.

The establishment of transition houses started in the 1970s. Women recognized and acknowledged that their husbands beat them. The solution was seen to be providing a safe place for individual women in an emergency shelter, often called a transition house.

The reproductive health issues at that time were access to birth control and abortion services. Legislation passed by the federal government in 1969 legalized birth control and allowed abortion under certain conditions. In this province, two different approaches were taken to these issues. To meet birth control needs, groups emerged in both Corner Brook and St. John's to provide services, while other groups put their efforts into repealing the federal abortion law.

By the time the 1980s arrived, women could see that working issue by issue was not enough. Analysis by feminist researchers began to identify many systemic changes needed before equality could be reached. A parallel analysis was occurring in the health care field with identification of the need for a multifactorial approach if health was to improve.

One project which had identified the need for systemic change to solve health problems was the Women's Health Education Project (WHEP), a joint effort of the Women's Institute and the St. John's Status of Women Council. Funds from the Health Promotion Directorate of Health and Welfare Canada allowed the groups to work together from 1980 to 1984. This project was the first time women in this province were asked to identify their problems and their solutions. The goal of the project was to develop women's capabilities

to sustain and promote health for themselves, their families, and their communities. There were three strategies developed to meet this goal:

(1) to make oral and written information on human development and health available to a wide segment of Newfoundland and Labrador through the women of the province;
(2) to provide information on subjects which women have identified as problems in their communities;
(3) to develop a network among women involved in health care as employees, volunteers, and consumers by bringing them together to discuss needs and services, by identifying gaps in services with a view to applying knowledge and resources to the specific needs of communities, and by looking at the existing health care systems and planning ways to better use them.

The board of directors tried very hard to have few preconceived ideas about health problems and solutions. This is consistent with the feminist principle of letting women speak for themselves. During the life of the project the ideas of what had to be done, what it was possible to do, and ways to make things happen changed as control over the project's direction passed from the board of directors to the women themselves.

Women were asked in a survey to relate their own problems, the concerns of their families and of their communities. This information was then used to decide on topics for workshops which were to be organized around the province.

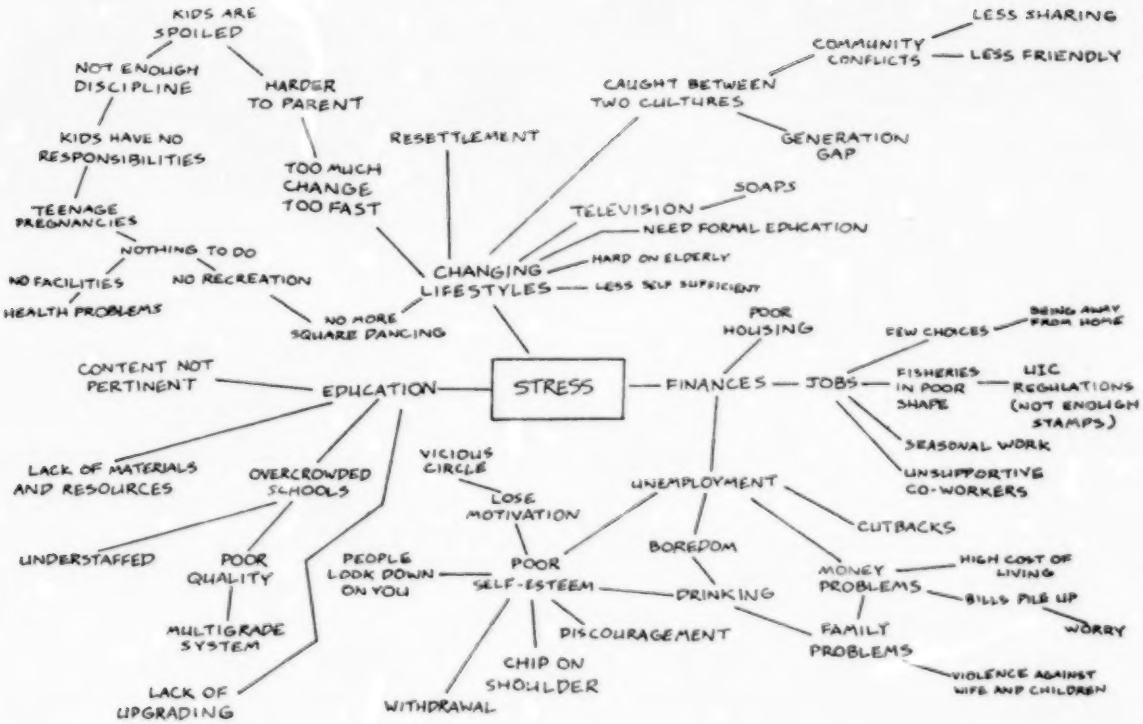
What did the women say? There were many concerns, but they could be grouped into five areas: (1) eating habits, (2) alcohol, drug and tobacco misuse, (3) mental health, (4) services (medical and community), and (5) reproductive health. Workshops were designed in a developmental way with three parts: an introduction, a session for discussion of causes, and a solution session. The introduction was meant to help identify and assess the problem from the individual's point of view. The discussion sessions prompted a closer look at other factors (social, economic, cultural, and political) in women's lives which affected the problem. The solution session focused on developing strategies to deal with the problem.

The following is a summary of the things women said about stress, services (medical and community), reproductive health, and nutrition. Addictions (alcohol, tobacco, and drug) were identified in the survey as a problem and a workshop was developed on this topic, however, no one asked to have the workshop given.

The information is presented in the form of a web chart. Each group started with a problem or area of concern and was encouraged to develop and express ideas and feelings around the central topic. The record of this process looks like a web. The web charts presented here were not actually done by women in the workshops, but have been drawn based on their words.

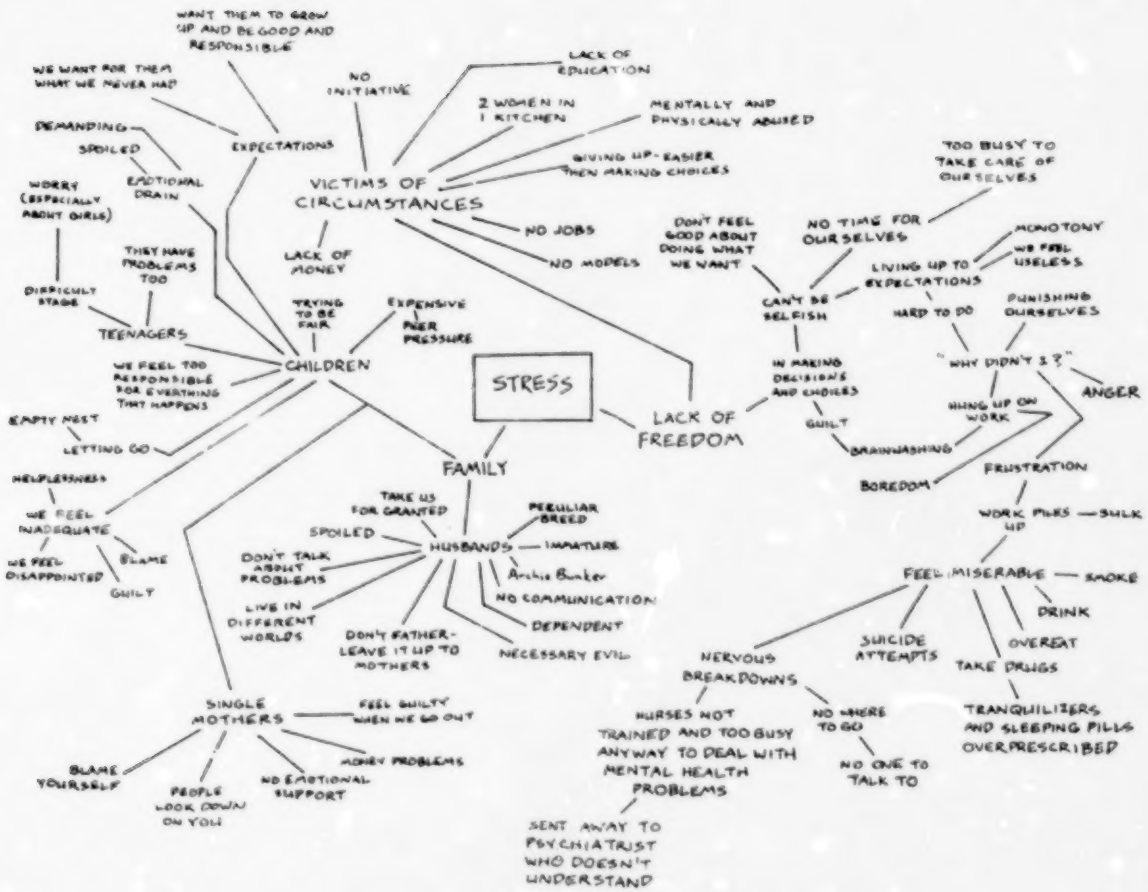
After each web is a series of tables, which give some form to the possible solutions identified by the women. This is in no way a complete listing of solutions to all the problems indicated in the web charts, but it does represent those that were recorded by the Women's Health Education Project.

STRESS



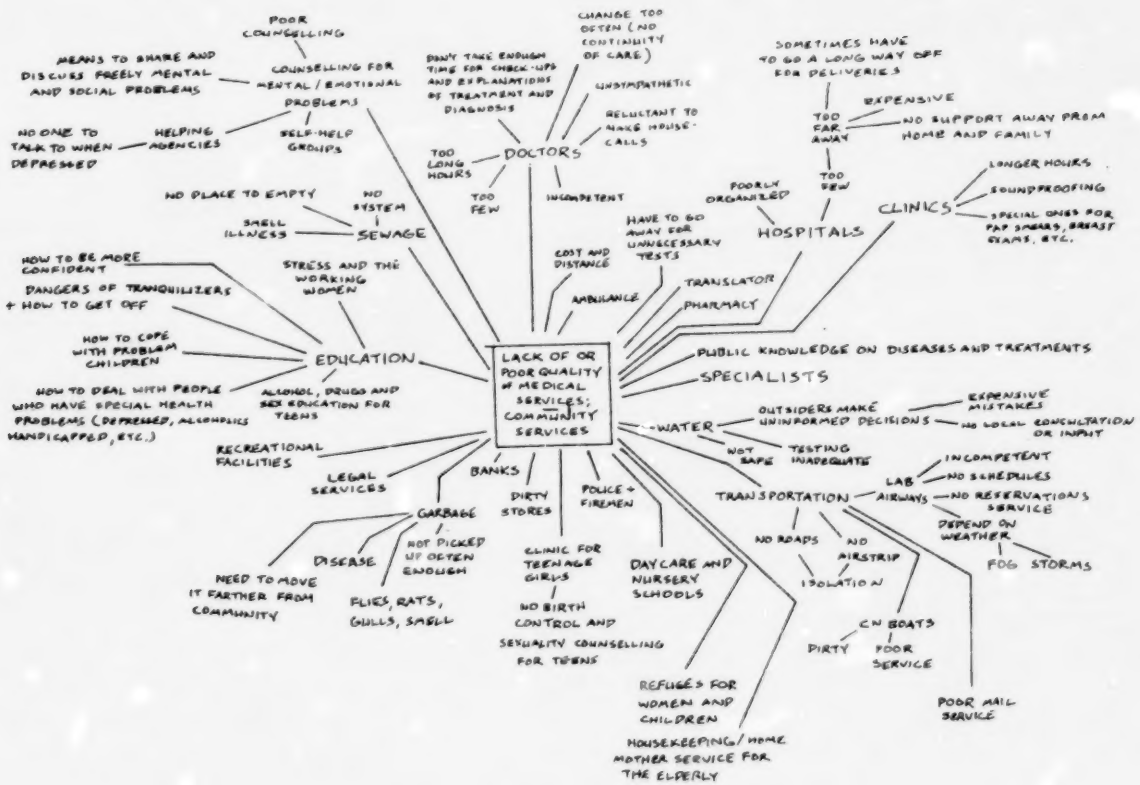
Because stress was talked about by the women so much, it was necessary to have two charts to include all the information. There are no real lines of demarcation here, as many of the topics overlap and merge into each other. The suggested means of coping are varied and range from the simple acquisition of information to intimate sharing in group situations.

STRESS


STRESS
CHILDREN
FAMILY
LACK OF FREEDOM
VICTIMS OF CIRCUMSTANCES
EXPECTATIONS
WANT THEM TO GROW UP AND BE GOOD AND RESPONSIBLE
WE WANT FOR THEM WHAT WE NEVER HAD
NO INITIATIVE
LACK OF EDUCATION
2 WOMEN IN 1 KITCHEN
MENTALLY AND PHYSICALLY ABUSED
GIVING UP - EASIER THEN MAKING CHOICES
DEMANDING
SPOILED
EMOTIONAL DRAIN
WORRY (ESPECIALLY ABOUT GIRLS)
DIFFICULT STAGE
THEY HAVE PROBLEMS TOO
TEENAGERS
LACK OF MONEY
NO JOBS
NO MODELS
TRYING TO BE FAIR
EXPENSIVE
PEER PRESSURE
WE FEEL TOO RESPONSIBLE FOR EVERYTHING THAT HAPPENS
EMPTY NEST
LETTING GO
HELPLESSNESS
WE FEEL INADEQUATE
WE FEEL DISAPPOINTED
BLAME
GUILT
TAKE US FOR GRANTED
PECULIAR BREED
SPOILED
HUSBANDS — IMMATURE
DON'T TALK ABOUT PROBLEMS
Archie Bunker
NO COMMUNICATION
LIVE IN DIFFERENT WORLDS
DEPENDENT
DON'T FATHER - LEAVE IT UP TO MOTHERS
NECESSARY EVIL
SINGLE MOTHERS
FEEL GUILTY WHEN WE GO OUT
MONEY PROBLEMS
BLAME YOURSELF
PEOPLE LOOK DOWN ON YOU
NO EMOTIONAL SUPPORT
DON'T FEEL GOOD ABOUT DOING WHAT WE WANT
NO TIME FOR OURSELVES
TOO BUSY TO TAKE CARE OF OURSELVES
CAN'T BE SELFISH
LIVING UP TO EXPECTATIONS
MONOTONY
WE FEEL USELESS
HARD TO DO
PUNISHING OURSELVES
IN MAKING DECISIONS AND CHOICES
GUILT
BRAINWASHING
"WHY DIDN'T I ?"
ANGER
HANG UP ON WORK
BOREDOM
FRUSTRATION
WORK PILES — SULK UP
FEEL MISERABLE — SMOKE
DRINK
OVEREAT
TAKE DRUGS
TRANQUILIZERS AND SLEEPING PILLS OVERPRESCRIBED
SUICIDE ATTEMPTS
NERVOUS BREAKDOWNS
NURSES NOT TRAINED AND TOO BUSY ANYWAY TO DEAL WITH MENTAL HEALTH PROBLEMS
SENT AWAY TO PSYCHIATRIST WHO DOESN'T UNDERSTAND
NO WHERE TO GO
NO ONE TO TALK TO

STRESS	
MONEY/JOBS	• budget • more permanent jobs • reduction of interest rates • craft co-ops • career exploration for women • employment grants such as LEAP
FAMILY	• time together for husband and wife • laughter • thanks and appreciation • neighbours • encourage children to talk to parents and vice versa • interpersonal relationships in general are important to a couple's relationship • family "council" meetings where everyone has equal rights
BY ONESELF	• schedule time; organize daily chores • plan for being alone • exercise • enough rest • planning for different phases of our lives • hobbies • interests outside the home
DOCTORS	• make them stop prescribing Valium • teach people to talk to doctors
COMMUNITY SERVICES	• home care for aged and/or sick invalids • day care centre • more activities for children and teens • help dealing with friends with specific problems • more police control to prevent trafficking • clinics for teenage girls • raise drinking age • homes and shelters for battered women

SERVICES (MEDICAL AND COMMUNITY)



The services web chart clearly indicates the problems women have identified with respect to both the poor quality and shortage of medical and community services. For some of these, the solutions are obvious; but for others, a more detailed analysis is necessary.

MEDICAL	
DOCTORS	• more of them • more frequent visits by them • more permanent family physicians • house calls • more time to explain treatment and diagnosis • more realistic working hours • demand information from doctors and make them more aware of our wishes
OTHER PERSONNEL	• dentists and dental services • counselling on nature of diseases and treatments
COSTS	• drug and dental plan insurance • subsidized transportation to medical services
FACILITIES	• pharmacies in all communities • clinics with soundproof walls
OTHER	• translation services in St. John's • in-service education at hospitals on geography and native peoples • take concerns of Labrador people to Grenfell Regional Health Services Board

COMMUNITY	
GOVERNMENT	• lobby for improvement • organize a town council • withdraw support from MHAs • start a local programme with local leadership
WORKSHOPS/CLASSES/EDUCATION	• home economics classes • workshops on nutrition and housekeeping • school essay contests on health-related problems
FACILITIES	• install water and sewerage • empty sewage at special sites • clean up garbage around homes and community • better sanitation in meat departments • youth centre with programmes for children and teens • build a playground or improve existing one

REPRODUCTIVE HEALTH

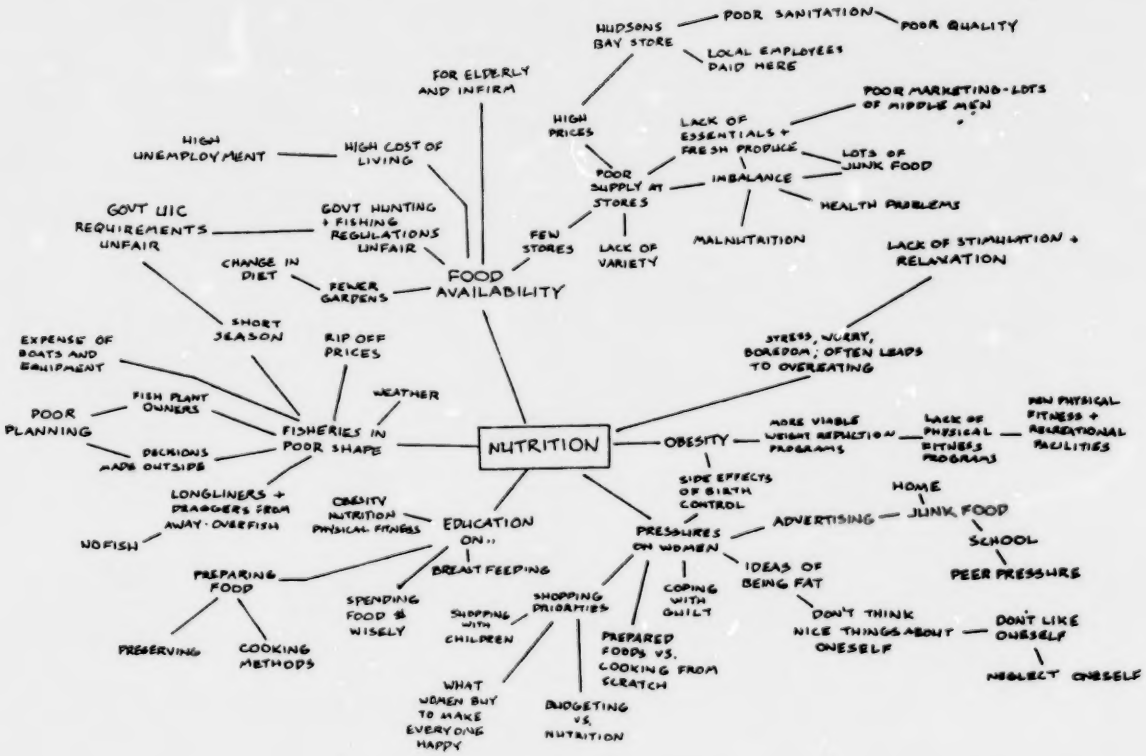
Throughout the project women expressed concern and fear in relation to their bodily functions. They also talked about the lack of recognition of "women's problems" by the medical profession.

The greatest problem I have encountered as a woman is that we are told that our problems are women's problems, and if we ignore the pain or whatever, it will go away.

- quote from the survey

REPRODUCTIVE HEALTH	
WRITTEN INFORMATION	• menopause • birth control and family planning • cancer • health for teens • catalogue to show where resources (films, books, etc.) are available • translated into native language
WORKSHOPS/CLASSES	• family planning for parents and children • breast, cervical, and uterine cancers • sexuality for children • fertility and birth control • hygiene and health care • breast self-examination • how to raise teenagers • pre-natal
GROUPS	• self-help • peer counselling o LaLeche league o women of all ages get together to share their experiences
CLINICS	o planned parenthood o for teenage girls o premenstrual

NUTRITION



Nutrition was identified as a problem throughout the project, particularly in the survey. Most times, however, it was mentioned in conjunction with food availability, obesity, and junk food (especially for children).

NUTRITION	
STORES/FOOD	• more food stores • better selection of food (ask storekeeper to buy items you want) • watch "Marketplace" to get hints • pick berries • freeze food • organize farmers' markets or sell produce in local stores • change eating habits to more well-balanced meals and snacks • approach co-op movement to help coastal communities handle their own food supply
OBESITY	• weight groups • exercise programmes • nutritional advice • relaxation training
CHILDREN/SCHOOLS	• concerned parents get together and demand nutritious snacks and lunches in schools • organize some activities during recess • try to get advertisements off television (petition CRTC) • take responsibility and turn off television

HOW THE SURVEY WAS DONE

Women in women's groups, groups whose focus is women's health, and health professionals were contacted. Individuals from different fields such as social work, medicine, nursing, as well as from different geographical areas of the province, were interviewed. The listing of all the people, their place of residence, and the group with which they are affiliated or the group of which they are members, is contained in appendix A. A total of twenty-five surveys were done - sixteen with representatives of the women's community and nine with health professionals.

The format for the survey was developed by the Health Promotion Directorate of the federal Department of Health and Welfare in their 1986 review of women's health. A sample of the questionnaire is contained in appendix B. Several methods were used to do the interviews: fifteen people were interviewed face to face; during each of two teleconferences three women answered the questionnaire; one interview was conducted on the telephone; and one questionnaire was completed by four women as a group and mailed to me. All but one of the people interviewed for this paper are women.

One of the principles of feminist research is that women themselves must be the ones to say what they want and need. So women were asked to define their own health needs.

Health was defined in the questionnaire only in that respondents were asked about "women's health and well-being, both mental and physical." The respondents answered the questions based on their own definition of health, which turned out to be broad. Women talked about such things as the lack of water and sewerage, the stress resulting from unsure income, lack of friends or support, lack of knowledge of their own bodies, battering by men, the amount of time they have to wait for their pap smear results, and the lack of public transportation for the disabled and for rural women.

It is important to use this broad definition of health as defined by women, which is consistent with the World Health Organization's definition of health. WHO says health is a complete state of physical, mental, and social well-being, and not merely the absence of disease or infirmity.

ANALYSIS OF THE SURVEY

There are many examples of issues which today are matters of public discussion, but which when first raised by the women's community were laughed at, seen as unimportant, or viewed as rare occurrences. The laughter in the Canadian House of Commons when the issue of wife battering was raised, and the dismissal of sexual assault of female children by adult males as a rare occurrence, are both examples of this.

Analysis of this survey is based on the premise that everything women say is important. The aim was to record every issue, problem, and solution mentioned. Numbers are not given, i.e., this paper does not say how may people raised the issue of lack of access to abortion services or of lack of access to information on osteoporosis.

The comments were grouped according to the determinants of health as presented in *A New Perspective on the Health of Canadians (the Lalonde Report).* Four determinants of health - life style, the environment (social, economic, physical), biological factors, and factors related to health care organization - were identified by Lalonde. This method of analysis was chosen because it is the one used in the 1986 *Newfoundland Health Review*, the most recent publication from the provincial Department of Health.

Question 1

I would like to identify current major concerns relating to women's health and well-being, both mental and physical. What do you think are the most important problems or issues for women at the present time?

ENVIRONMENT: ECONOMIC

(1) women's economic dependence
(2) Women's health cannot be separated from our status in society and thus our poverty.
(3) high unemployment and lack of finances

ENVIRONMENT: SOCIAL

(1) women's feelings of lack of self worth

(2) women's responsibility for caring for children

(3) battering, both physical and mental, of women

(4) stress

(5) incest

(6) discrimination

ENVIRONMENT: PHYSICAL

(1) lack of public transportation, both in rural and in urban areas. Please note the special needs of women who are disabled.

(2) lack of water and sewerage systems

(3) poor housing

FACTORS RELATED TO THE ORGANIZATION OF HEALTH CARE

(1) Women rarely question the advice given by such advice givers as clergy and/or physicians.

(2) lack of support systems, especially for immigrants and for women who must leave their communities for care (i.e., to have a baby). Lack of a support system leads to loneliness and sometimes to physical problems.

(3) Women's medical problems are often dismissed as being unimportant or neurotic.

(4) the attitude that you are now sick because you were a victim (of sexual assault) and that you need me (a psychiatrist) to get better

(5) Physical and social services do not provide services at hours convenient for working women. Maybe work must change to suit the many demands placed on women.

(6) inappropriate treatment for sexual assault survivors, except at the Health Sciences Centre

(7) most medical services are in St. John's

(8) lack of counsellors and therapists

(9) constant change-over in nurses

(10) no specialists in rural areas

(11) shortage of psychiatrists

(12) no gynaecologist ever went to Nain

(13) no women physicians

(14) physicians who do not know how to talk and how to listen, thus a lack of effective communication. Women want to be an equal, active participant when interfacing with health care professionals.

(15) control of health care system by paternalistic men

(16) no native health professionals

(17) many medical services not covered by health care plan, for example, dentists

(18) lack of medical doctors who use non-medical models of care

(19) lack of holistic approach to medicine

(20) lack of support groups, such as parentage groups

(21) women in wheelchairs made to feel small by physicians when asking for information on birth control

(22) information needed on many topics, such as nutrition, birth control, our bodies, menopause, how our physical and emotional selves fit together, options when pregnant, premenstrual syndrome

(23) lack of reproductive freedom, especially lack of abortion services

(24) Some women have never had a pap smear.

(25) teenage pregnancy

(26) whole area of sexuality

(27) infertility

(28) new reproductive technologies

(29) how to provide prenatal care; questions about the role of midwives; dissatisfaction among women who must leave their community to have their baby

(30) long time getting pap smear results

(31) the large number of prescriptions for drugs

(32) drugs taken in pregnancy such as DES

LIFESTYLE FACTORS

(1) sexually-transmitted diseases

(2) AIDS

(3) increase in cervical cancer

(4) addictions such as tobacco, alcohol, psychotropic drugs

BIOLOGICAL FACTORS

(1) osteoporosis

(2) cancer of the breast

Question 2 (factors underlying health)

Women's health and well-being still are affected by our physical make-up, by our behaviour, and by our physical environment. It is also affected by the social environment in which we live. This refers to factors such as the way society views women's roles, women's work and so on. In your opinion, what are the factors and situations that have the most serious negative impacts on women's well-being, both physical and mental?

ENVIRONMENT - ECONOMIC

(1) Our economic situation has the biggest effect on our well-being. Women earn 57 percent of what men earn. Poverty due to such things as unemployment, low wages, and small pensions is the lot of many women in Canada.

(2) Women who are doubly disadvantaged, such as women who grew up in institutions, have no dreams because no one ever thought of them as productive.

(3) lack of equal political representation

(4) the double role of women in the paid work force. Women are expected to be "super" mom, "super" worker, "super" organizer, which leads to stress. Society has to change its expectations. It is not each individual's failure.

(5) little flexibility in job situations

(6) Women's work in the home is not seen as important.

(7) the denial of decent employment

(8) women's lack of education

ENVIRONMENT - SOCIAL

(1) lack of self esteem because of the low value society puts on us. This is destructive because if you view yourself as unimportant, why bother to change your situation? This lack of self esteem seems to lead to a lack of independent thinking. Support groups and/or activities to increase self-esteem are needed.

(2) emotional isolation due to lack of a support system

(3) Women's lib told women that what they are doing in the home was no good and now women do not know who they are.

(4) The male view of the role of women is archaic in some instances. Women are supposed to be beautiful, not bright. Immigrant women seen as an easy mark.

(5) Women carry the main responsibility for the family.

(6) The sanctioning of violence against women in all its forms, including emotional and psychological abuse, must stop.

(7) People do not share their experiences of health and illness therefore see themselves as the only one with that problem. They do not see the patterns of being in a male-dominated world.

ENVIRONMENT - PHYSICAL

(1) isolation due to geography

(2) long winter

FACTORS RELATED TO THE ORGANIZATION OF HEALTH CARE

(1) our medical system which is hierarchical, controlled by experts, and paternalistic

(2) services which are not designed to accommodate our many roles, eg. the lack of child care facilities in fitness centres

(3) lack of access to information

(4) lack of access to abortion services

(5) the lack of a role for midwives

(6) shortage of physicians

LIFESTYLE FACTORS

nil

BIOLOGICAL FACTORS

nil

Question 3

What about factors that facilitate health? What are the factors and situations in our society that have the most important positive impacts on women's well-being, both physical and mental?

ENVIRONMENT - ECONOMIC

(1) all the work to improve the status of women especially the work done to free women from the stereotypes under which we have lived our lives

(2) school classes now held in Inuktitut

(3) adequate food

(4) satisfactory employment

(5) secure income

(6) having options - being able to stay home with children, being able to go to paid wo being able to afford to give up social assistance (i.e., pay at job would make up for loss of benefits)

(7) Community colleges are more responsive to women's needs.

ENVIRONMENT - SOCIAL

(1) the increased involvement of men in family responsibilities

(2) Women are becoming more involved in politics.

(3) friends

(4) The gradual development of community centres such as Rabbittown in St. John's.

(5) women's groups such as the Women's Institute

(6) access to good sex

(7) good family life

(8) good child care

(9) leisure

(10) affordable, accessible social services, which unfortunately are rare

(11) fitness programmes

(12) mobility

ENVIRONMENT - PHYSICAL

(1) water and sewerage systems

(2) public transportation systems

(3) housing projects especially the Torngat Project in Labrador

(4) the physical beauty of the place

(5) no fear of children being kidnapped

FACTORS RELATED TO THE ORGANIZATION OF HEALTH CARE

(1) the Supreme Court decision in January of 1988 striking down the abortion law

(2) the larger numbers of women being accepted in medical school

(3) open lines of communication with professionals

(4) knowledge from a variety of sources, including television talk shows, pre- and post-natal classes, nurses, and doctors

(5) the Community Health Representatives, which are available in many native communities in Labrador

(6) understanding health care professionals, especially public health nurses and Community Health Representatives

(7) services which are run by women for women, such as transition houses

(8) greater availability of fitness centres

(9) support groups, such as the empowerment group run by the transition house in St. John's; social opportunities to get together, such as bingo

(10) the evolving support system that looks at the whole person when helping

(11) technical aids for the disabled such as "Alexander" which is a voice-operated device that can activate electrical switches

(12) a progressive maternity hospital

LIFESTYLE FACTORS

(1) Doing breast self examinations.

(2) Getting pap smears.

(3) Eating appropriate diets.

(4) Getting exercise.

BIOLOGICAL FACTORS

nil

Question 4 or 5 (Ask either question 4 or 5.)

Your own activities have centred around: (1) immigrant women, (2) isolated rural women, (3) poor women, (4) disabled women, (5) others.

Question 4

What are the key health issues for them?

Question 5

Are you aware of groups of women in our society who are particularly at risk for health problems? If so, who are these groups, and what are the key health issues for them?

WOMEN WHO ARE BATTERED

(1) They are doubly oppressed women therefore have a higher chance of being victimized. When that happens their chances of being believed are smaller than privileged women. "Your honesty is perceived as being directly related to your economic worth."

(2) We do not give specialized knowledge to immigrant women as we do to local women (eg., there are no pamphlets in women's own language saying if your husband beats you it is a crime in this country).

WOMEN WHO ARE POOR

(1) These women are sick more often, as are their children. This is due in part to lack of money to buy nutritious foods, lack of knowledge, and lack of energy to prepare food.

(2) Birth control methods are expensive and many are not covered by drug plans (private or public).

(3) lack of transportation

(4) lack of child care

(5) lack of abortion services

(6) The working poor have little public help available.

SINGLE MOMS

(1) depression

(2) no child care, therefore no way to continue education

(3) little money, thus not much time away from children

(4) lack of transportation

WOMEN WHO ARE DISABLED

(1) lack of employment

(2) isolation

(3) lack of transportation

(4) doctors often unaware of their needs

(5) Things are done to them (eg., Depo Provera is still being given to them).

(6) Many are sheltered by their families and never achieve autonomy.

(7) lack of privacy in institutions

(8) Smoking bothers them.

(9) Awareness is the biggest issue. Please see women who are disabled, not disabled women.

TEENAGERS

(1) Lack of knowledge of their bodies leads to delay in seeking medical help when pregnant. They are often unaware of risks they are taking sexually.

(2) need help if they become mothers

(3) lack of birth control services

(4) There is not enough support for all the pressure they are under.

(5) Those who live on the coast of Labrador are exposed to all the worst aspects of our culture.

ELDERLY WOMEN

(1) Cheques are issued once a month, which makes it hard to budget.

(2) poverty (i.e., Many elderly women are widows whose incomes stop when their husbands die.)

(3) lack of housing

(4) Families take their money.

(5) They are socialized to believe doctors know what is best, and as a result they take a lot of drugs.

(6) lack of transportation

MIDDLE-AGED WOMEN

(1) breast and cervical cancer

(2) depression

(3) poverty

ADDICTED WOMEN

(1) few treatment options

NORTHERN LABRADOR WOMEN

(1) Their health status (as measured by traditional health indicators) is worse than women who live elsewhere in province.

Question 6 (changes needed)

We've talked about health issues, about factors underlying health and well-being, and about groups at special risk for problems. The focus of the next question is on changes that are needed to bring about improvements in women's well-being. For example, there could be changes in legislation, or in programmes and services, or maybe in available resource material. What are some of the changes which could lead to improvements in the health and well-being of women?

ENVIRONMENT - ECONOMIC

(1) recognition of volunteer work as work when applying for paid work

(2) improved child care services

(3) a government subsidy on day care for women both at home and at work, since the present services are inadequate

(4) Change income tax laws. For example, child support payments are deductible items for the men, but the women have to claim them as income.

(5) better tax breaks, eg., rent being tax deductible

(6) a better way to distribute the wealth

(7) Remove sexism from the educational system.

(8) mandatory education in human sexuality

(9) more involvement of women in decision-making in education

(10) Programmes must be designed to reflect women's lives, for example, child care in schools, to allow women who were mothers at an early age to complete high school. It is not good enough to say this programme is open to men and women.

(11) Community Colleges are seen as a way for women to continue their education.

(12) Retraining programmes are important.

(13) The introduction of women's programmes will require money.

(14) Middle-class women want to get into system and compete with men. This will never be enough for the rest of the women.

(15) jobs

ENVIRONMENT - SOCIAL

(1) A value must be put on what women do.

(2) recognition of the role of motherhood, which here is a thankless job

(3) Free women from violence.

(4) Health is a social and economic concern.

(5) Women need to learn to express their anger.

(6) men to take more of a share in responsibility for parenting. The issue is responsibility.

(7) Traditional values make it difficult for girls when they want to do something different. May lead to identity crisis. These girls need support.

ENVIRONMENT - PHYSICAL

(1) Provision of more housing designed with women's lives in mind.

FACTORS RELATED TO HEALTH CARE ORGANIZATION

(1) Everything should be done with the goal of well-being in mind, eg., we should not be putting energies into promoting the arms race.

(2) Women must be involved in defining their problems, the causes, and the solutions.

(3) acknowledgement that problems that women face are different from problems that men face

(4) change in whole focus of health thus getting away from system which is medically based to one which is preventative and community based

(5) endorsement of the WHO "Health for All" by involving women in identifying health needs and planning the services to answer those needs. This will be threatening to health care providers.

(6) Health care professionals must become more approachable, provide more information, and not foster dependency.

(7) Professionals' knowledge about women's situation in Newfoundland needs to be increased.

(8) Attitude of many medical people towards women is paternalistic. This must change.

(9) Women gave several examples of equipment needed: for example, the x-ray machine at North West River needs repair; hospitals want equipment for mammograms and culdoscopy.

(10) Educate Inuit to become health professionals.

(11) services of Inuktitut translators to be available where needed

(12) Support services for battered women in rural areas are inadequate.

(13) Battered women do not want to be pressured to leave their communities.

(14) increased attention on family violence

(15) A wider range of care-givers should be funded by health care insurance, eg., dentists.

(16) The services available from Department of Social Services must be standardized.

(17) The government should fund support groups organized by community groups, eg., premenstrual syndrome groups, groups for women who abuse their children, and parenting groups.

(18) government funding for volunteer groups which deal with health issues: an example would be Planned Parenthood

(19) Use lay women in educational programmes.

(20) Services must be accessible to any disabled women: for example, phones must be adapted for use by the deaf community.

(21) Funding must be available to allow women to come together to talk about things that are important to them.

(22) There are no services for sexually-assaulted teenagers.

(23) counselling services for pregnant teenagers

(24) support services for single mothers

(25) Pap smear clinics should be run by female professionals.

(26) There should be more female physicians/gynaecologists.

(27) All nursing stations should have two nurses.

(28) Specialists should visit communities.

(29) A hostel next to the hospital in Happy Valley/Goose Bay would help.

(30) There needs to be a chronic care centre/senior citizens' home on the Coast of Labrador.

(31) new nursing station for Hopedale and Nain

(32) training programmes for homemakers and community health representatives

(33) the improvement and/or the development of home support services; for example, women caring for their elderly parents with little or no support

(34) Educational material must be designed for low literacy. Funds must be allocated to the Department of Public Health to do this.

(35) Use more ways to get out health messages, eg., advertise on the "soaps."

(36) All women's issues are being professionalised. We need to realize that women can trust their own knowledge and help each other. As governments take over the services originally started by women they pull the financial plug on the original women's services. This happened in Ontario, for example, when funds were withdrawn from feminist sexual assault centres as the government began to fund services in hospitals.

(37) We want control of our bodies; for example, most hospitals still require the permission of the husband for the women to get a tubal ligation.

(38) need for public education on other models of care in such areas as childbirth. If all women who had a baby in the last year were asked about the experience, most would say they were satisfied because they have nothing else with which to compare it. Their only other knowledge might be from their grandmother of the time when women died in childbirth.

(39) Medical professionals are set up as marvellous purveyors of knowledge.

(40) easier access to information about such things as cancer of the cervix

(41) Establish family planning positions around the province.

(42) Establish a forum for people presently involved in women's health to start the ball rolling.

LIFESTYLE FACTORS

nil

BIOLOGICAL FACTORS

nil

LEGISLATION

(1) Legislation itself has not produced change for women.

(2) no recriminalization of abortion

Question 7 (activities)

I am trying to get a picture of some things going on around the province related to women's health. Could you tell me what you are aware of in the way of programmes, groups, networks, resources?

These groups/programmes were seen as positive.

(1) Women for Sobriety

(2) church groups

(3) women's centres

(4) TOPS (Take Off Pounds Sensibly)

(5) Canada Employment and Immigration

(6) transition houses

(7) Family Practice Unit at the Health Sciences Centre

(8) Cancer Society

(9) DES Action Canada

(10) Al-Anon

(11) crisis line in Marystown

(12) child protection teams

(13) food banks

(14) Alcohol and Drug Dependency Commission

(15) Stephenville Status of Women

(16) National Film Board

(17) Mercy Residence for Girls - St. John's

(18) pre-natal classes

(19) Single Parents Association - United Church

(20) Labrador Inuit Health Commission has a new extended coverage on drugs, dental services, and transportation.

(21) Incest Survivors Group - St. John's

(22) Child Abuse Victims Group - St. John's

(23) Mental Health Services for Children and Adolescents - St. John's

(24) Criminal justice system has improved for women.

(25) Multi-Cultural Women's Organization

(26) Department of Health is producing a reproductive care manual.

(27) public health nurses

(28) Peer Counselling Group - Grand Falls

(29) Well Women's Clinic at hospital on Bell Island

(30) literacy programme at Rabbittown Community Centre - St. John's

(31) Single Moms Group in Corner Brook

(32) Women on the Outside run by John Howard Society

(33) Training for Tomorrow

(34) Women Interested in Successful Employment (WISE)

(35) Career Exploration for Women

(36) Planned Parenthood, especially their support groups

(37) caribou plant

(38) Women's Health Education Project - unfortunately public health system never got connected

(39) Women's Institute, especially their *Widow's Handbook*

Question 8 (other comments)

[These are all quotes which did not fit in elsewhere.]

(1) There is need of a study on women's role in maintaining family life.

(2) People need to be supported in the care they give such as the care women give the elderly.

(3) People should not concentrate on traditional issues such as teenage pregnancy but on overall trends such as heart disease.

(4) Remove the barriers so we can all participate.

(5) We (immigrant women) need to perform 100 times better to be recognized.

(6) When we empower people traditional structures will be threatened.

(7) The boys are not going to fund the revolution.

CONCLUSIONS AND RECOMMENDATIONS

(1) Actions directed to improving women's health need to be integrated and coordinated with efforts to improve women's social status.

(2) Significant improvements in women's health and well-being can be achieved only if there are general gains in the status of women in education, employment, and representation in decision-making roles.

(3) Women must be active participants in the process of developing health (mental and physical) programmes at all levels and stages.

(4) Health programmes must avoid exploiting the voluntary nature of much of women's health care for others.

(5) Health policies must acknowledge women as the primary provider of health care in this country.

(6) Abortion must not be recriminalized.

(7) All programmes and services which are set up must validate women's experience.

(8) Women must have an adequate income, such as a guaranteed annual income, which acknowledges women's work in the productive sphere as well as the reproductive sphere.

(9) There must be child care services to meet the needs of women.

(10) Government funds must be used to finance new and existing services which were developed by women for women, such as transition houses.

(11) There must be a political will to redirect the health care field from a curative to a preventive model.

(12) Develop a five-year provincial plan on health care to address these issues.

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APPENDIX A

LIST OF PEOPLE INTERVIEWED

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APPENDIX B

WOMEN'S HEALTH PROJECT INTERVIEW PROTOCOL

Background Information

Name

Address

Phone

Group

Paid/Unpaid

Brief summary of respondent's past and present activities around health and social issues:

I would like to identify current major concerns relating to women's health and well-being, both mental and physical.

(1) What do you thing are the most important problems or issues for women at the present time?

Factors Underlying Health

Women's health and well-being is affected by our physical make-up, our behaviour, and our physical environment. It is also affected by the social environment in which we live. This refers to factors such as the way society views women's roles, women's work and so on.

(2) In your opinion, what are the factors and situations that have the most serious negative impacts on women's well-being, both physical and mental?

(3) What about factors that facilitate health? What are the factors and situations in our society that have the most important positive impacts on women's well-being, both physical and mental?

Vulnerable Groups (Ask either 4 or 5.)

Your own activities have centred around (1) immigrant women, (2) isolated rural women, (3) poor women, (4) disabled women, (5) others.

(4) What are the key health issues for them?

(5) Are you aware of groups of women in our society who are particularly at risk for health problems? If so, who are these groups, and what are the key health issues for them?

Changes Needed

We've talked about health issues, about factors underlying health and well-being and about groups at special risk for problems. The focus of the next question is on changes that are needed to bring about improvements in women's well-being. For example, there could be changes in legislation, or in programmes and services, or maybe in available resource material.

(6) In your opinion, what are some of the changes in these or any other areas that could lead to improvements in the health and well-being of women?

Activities

I am trying to get a picture of some things going on around the province related to women's health.

(7) Could you tell me what you are aware of in the way of programmes, groups, networks, resources?

(8) Other comments

APPENDIX C

NAIROBI FORWARD-LOOKING STRATEGIES FOR THE ADVANCEMENT OF WOMEN

Paragraph 148

The vital role of women as providers of health care both inside and outside the home should be recognized, taking into account the following: the creation and strengthening of basic services for the delivery of health care, with due regard to levels of fertility and infant and maternal mortality and the needs of the most vulnerable groups and the need to control locally prevalent endemic and epidemic diseases. Governments that have not already done so should undertake, in co-operation with the World Health Organization, the United Nations Children's Fund and the United Nations Fund for Population Activities, plans of action relating to women and health in development in order to identify and reduce risks to women's health and to promote the positive health of women at all stages of life, bearing in mind the reproductive role of women in society and their responsibilities for bearing and rearing children. Women's participation in the achievement of Health for All by the Year 2000 should be recognized, since their health knowledge is crucial in their multiple roles as health providers and health brokers for the family and community, and as informed consumers of adequate and appropriate health care.

Paragraph 149

The participation of women in higher professional and managerial positions in health institutions should be increased through appropriate legislation, training and supportive action should be taken to increase women's enrolment at higher levels of medical training and training in health related fields. For effective community involvement to ensure the attainment of the World Health Organization's goal of Health for All by the Year 2000 and responsiveness to women's health needs, women should be represented in national and local health councils and committees. The employment and working conditions of women health personnel and health workers should be expanded and improved at all levels. Female traditional healers and birth attendants should be more fully and constructively integrated in national health planning.

Paragraph 150

Health education should be geared towards changing those attitudes and values and actions that are discriminatory and detrimental to women's and girls' health. Steps should be taken to change the attitudes and health knowledge and composition of health personnel so that there can be an appropriate understanding of women's health needs. A greater sharing by men and women of family and health care responsibilities should be encouraged. Women must be involved in the formulation and planning of their health education needs. Health education should be available to the entire family not only through the health care system, but also through all appropriate channels and in particular the educational system. To this end, governments should ensure that information meant to be received by women is relevant to women's health priorities and is suitably presented.

Paragraph 151

Promotive, preventive and curative health measures should be strengthened through combined measures and a supportive health infrastructure which, in accordance with the International Code of Marketing of Breast Milk Substitutes, should be free of commercial pressure. To provide immediate access to water and sanitary facilities for women, governments should ensure that women are consulted and involved in the planning and implementation of water and sanitation projects, trained in the maintenance of water supply systems, and consulted with regard to technologies used in water and sanitation projects. In this regard, recommendations arising from the activities generated by the International Drinking Water Supply and Sanitation Decade and other public health programmes should be taken into account.

Paragraph 152

Government should take measures to vaccinate children and pregnant women against certain endemic local diseases as well as other diseases as recommended by the vaccination schedule of the World Health Organization and to eliminate any differences in coverage between boys and girls. . . . In regions where rubella is prevalent, vaccinations should preferably be given to girls before puberty. Governments should ensure that adequate arrangements are made to preserve the quality of vaccines. Governments should ensure the quality of vaccines. Governments should also ensure the full and informed participation of women in programmes to control chronic and communicable diseases.

Paragraph 153

The international community should intensify efforts to eradicate the trafficking, marketing and distribution of unsafe and ineffective drugs and to disseminate information on their ill effects. Those efforts should include educational programmes to promote the proper prescription and informed use of drugs. Efforts should also be strengthened to eliminate all practices detrimental to the health of women and children. Efforts should be made to ensure that all women have access to essential drugs appropriate to their specific needs and as recommended in the WHO List of Essential Drugs as applied in 1978. It is imperative that information on the appropriate use of such drugs is made widely available to all women. When drugs are imported or exported governments should use the WHO Certification Scheme on the Quality of Pharmaceutical Products Moving in International Commerce.

Paragraph 154

Women should have access to and control over income to provide adequate nutrition for themselves and their children. Also government should foster activities that will increase awareness of the special nutritional needs of women; provide support to ensure sufficient rest in the last trimester of pregnancy and while breast-feeding; and promote interventions to reduce the prevalence of nutritional diseases such as anaemia in women of all ages, particularly young women, and promote the development and use of locally produced weaning food.

Paragraph 155

Appropriate health facilities should be planned, designed, constructed and equipped to be readily accessible and acceptable. Services should be in harmony with the timing and patterns of women's work, as well as with women's needs and perspectives. Maternal and child care facilities, including family planning services, should be within easy reach of all

women. Governments should also ensure that women have the same access as men to affordable curative, preventive and rehabilitative treatment. Wherever possible, measures should be taken to conduct general screening and treatment of women's common diseases and cancer. In view of the unacceptably high levels of maternal mortality in many developing countries, the reduction of maternal mortality from now to the year 2000 to a minimum level should be a key target for governments and non-governmental organizations, including professional organizations.

Paragraph 156

The ability of women to control their own fertility forms an important basis for the enjoyment of other rights. As recognized in the World Population Plan of Action and reaffirmed at the International Conference on Population, 1984, all couples and individuals have the basic human right to decide freely and informedly the number and spacing of their children; maternal and child health and family planning components of primary health care should be strengthened; and family planning information should be produced and services created. Access to such services should be encouraged by governments irrespective of their population policies and should be carried out with the participation of women's organizations to ensure their success.

Paragraph 157

Governments should make available, as a matter of urgency, information, education and the means to assist women and men to take decisions about their desired number of children. To ensure a voluntary and free choice, family planning information, education and means should include all medically approved and appropriate methods of family planning. Education for responsible parenthood and family life education should be widely available and should be directed towards both men and women. Non-governmental organizations, particularly women's organizations, should be involved in such programmes because they can be the most effective media for motivating people at that level.

Paragraph 158

Recognizing that pregnancy occurring in adolescent girls, whether married or unmarried, has adverse effects on the morbidity and mortality of both mother and child, governments are urged to develop policies to encourage delay in the commencement of child bearing. Governments should make efforts to raise the age of entry into marriage in countries in which this age is still quite low. Attention should also be given to ensuring that adolescents, both girls and boys, receive adequate information and education.

Paragraph 159

All governments should ensure that fertility-control methods and drugs conform to adequate standards of quality, efficiency and safety. This should also apply to organizations responsible for distributing and administering these methods. Information on contraceptives should be made available to women. Programmes of incentives and disincentives should be neither coercive nor discriminatory and should be consistent with internationally recognized human rights, as well as with changing individual and cultural values.

Paragraph 160

Governments should encourage local women's organizations to participate in primary health care activities including traditional medicine and should devise ways to support women, especially underprivileged women, in taking responsibility for self-care and in promoting community care, particularly in rural areas. More emphasis should be placed on preventive rather than curative measures.

Paragraph 161

The appropriate gender-specific indicators for monitoring women's health that have been or are being developed by the World Health Organization should be widely applied and utilized by governments and other interested organizations in order to develop and sustain measures for treating low grade ill health and for reducing high morbidity rates among women, particularly when illnesses are psychosomatic or social and cultural in nature. Governments that have not yet done so should establish focal points to carry out such monitoring.

Paragraph 162

Occupational health and safety should be enhanced by the public and private sectors. Concern with the occupational health risks should cover female as well as male workers and focus among other things on risks endangering their reproductive capabilities and unborn children. Efforts should equally be directed at the health of pregnant and lactating women, the health impact of new technologies and the harmonization of work and family responsibilities.

Paragraph 231

Governments should undertake effective measures, including mobilizing community resources, to identify, prevent and eliminate all violence, including family violence, against women and children and to provide shelter, support and re-orientation services for abused women and children. These measures should notably be aimed at making women conscious that maltreatment is not an incurable phenomenon, but a blow to their physical and moral integrity, against which they have the right (and the duty) to fight, whether they are themselves the victims or the witnesses. Beyond these urgent protective measures for maltreated women and children, as well as repressive measures for the authors of this maltreatment, it would be proper to set in motion long-term supportive machineries of aid and guidance for maltreated women and children, as well as the people, often men, who maltreat them.